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ABSTRACT

This document presents the program agenda and highlights from the one-day Robert Lee Sutherland Seminar held to examine the current status and the future of the elderly population of Texas. Included is the speech, "The Longevity Revolution" by Robert N. Butler, in which is discussed the gain in life expectancy, the feminization of aging, and the increase in the old-old age group, and which describes existing resources for the elderly. A second speech, "Constructing the Future of Aging" by George L. Maddox, provides a five-point agenda for mobilizing a societal project to construct the future of aging, the five points being: (1) a focus on the human life course; (2) a reshaping of health care; (3) an intergenerational contract which binds society together; (4) an integrated public welfare policy; and (5) demonstrating the art of the possible, or ways to improve the quality of life. Also included in these highlights are recommendations which could serve as guideposts for groups interested in making life more meaningful for older people. Recommendations are listed under the headings of Living Patterns and Changing Family Situations, Community Opportunities, Employment and Retirement Issues, Housing, and the Non-Anglo Elderly. (NRB)

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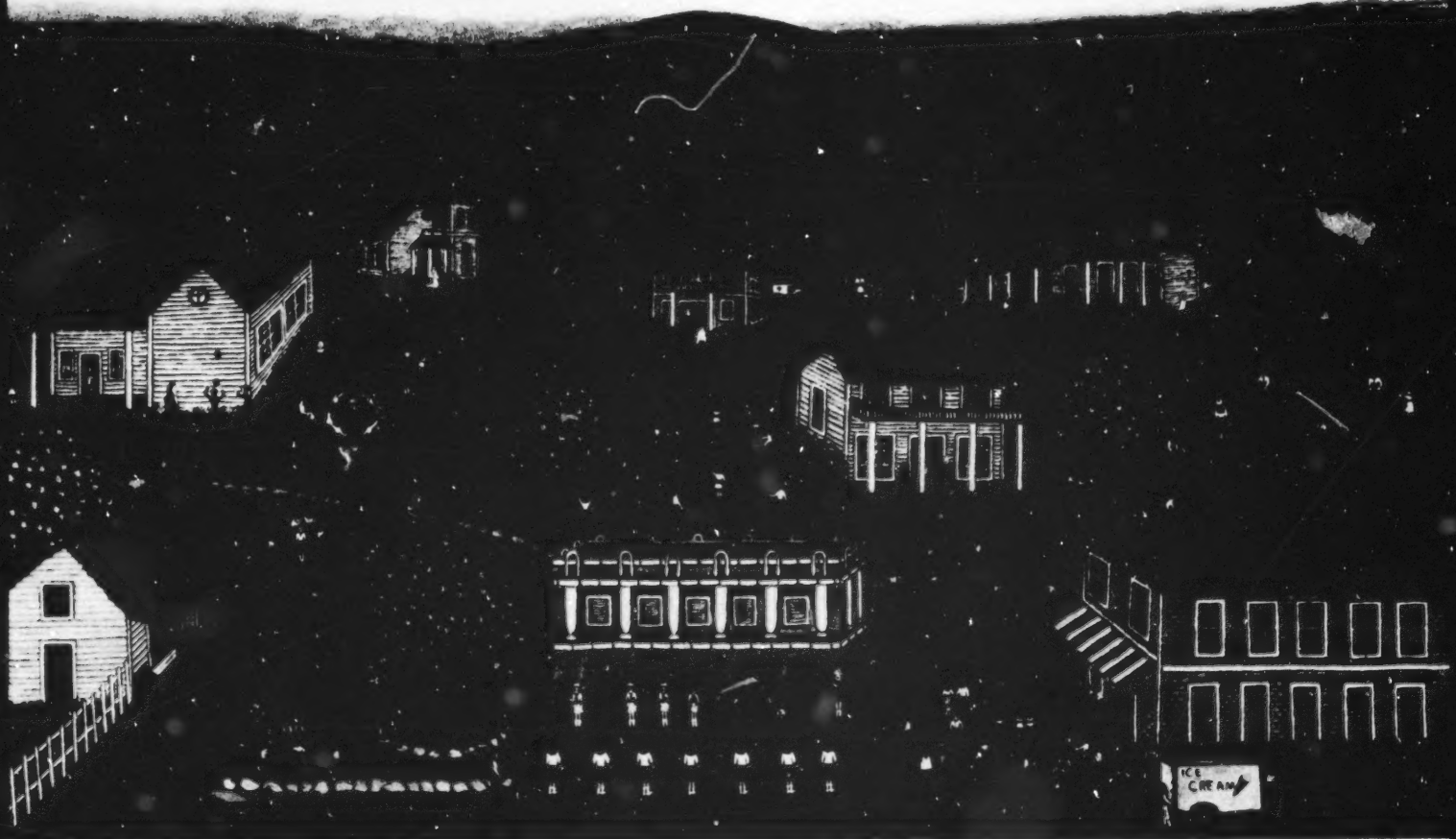

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Looking Forward: Texas and Its Elderly

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Highlights of the Fourth Robert Lee Sutherland Seminar

Looking Forward: Texas and Its Elderly

Hogg Foundation for Mental Health 1985
The University of Texas
Austin, Texas 78713-7998

Editors
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On the cover: Peach Season by Fannie Lou Spelce © 1969. The Hogg Foundation is grateful for permission to reproduce Mrs. Spelce's painting for use with materials of the Fourth Robert Lee Sutherland Seminar on "Looking Forward: Texas and Its Elderly."

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About the Artist

Fannie Lou Spelce registered for her first oil painting classes at an Austin museum when she was 59 years old and near retirement. She took one lesson. Identifying her work as "primitive," the instructor suggested she cease training. "Any advice . . . might ruin your style. Go home and paint whatever and however you wish. No one should influence you."

And so she has done for 19 years, still completing 8 to 12 canvases each year. Some refer to her style as *naive* or *untrained*. Whatever the description, it has attracted national critical acclaim.

New York City exhibitions have included the Museum of American Folk Art, the IBM Gallery of Science and Art, Webb and Parsons Gallery, and a one-woman show at the Kennedy Galleries. Her paintings have hung at the Dallas Museum of Fine Arts and in a "Women and Art" exhibit sponsored by the Dallas Chapter of the National Organization for Women.

In San Antonio, her work has been shown at the Witte Museum and in a one-woman show at the Institute of Texan Cultures. She has been featured artist in Austin at the State Capitol Rotunda, the Austin Heritage Society Antique Show, and the Gallery at Shoal Creek. She has also had a one-woman show at Austin's Laguna Gloria Art Museum.

Fannie Lou Spelce has been the subject of numerous magazine and newspaper articles, and her work has been cited in nationally-published books on folk art. Her work has graced covers of conference and academic programs and a commemorative poster. In 1980 she was named Outstanding Woman in the Arts by the American Association of University Women.

PROLOGUE AND PURPOSE

Old.
To the young it is a number.
To the elderly, a state of health.
To many families a problem.
Old is a symbol, a message.
It is despair or delight.
Indifference or integrity.
It is Lot's wife looking backward or Marc Chagall with eyes ahead.

Mindlessness or majesty; wondering or wandering—old has a chameleon-like quality in our society. Elusive as quicksilver, its essence is difficult to capture.

Yet encapsulating that essence, albeit briefly, became a goal of the planners of the Robert Lee Sutherland Seminar held in Austin in the spring of 1984. Earlier seminars, named after the Hogg Foundation's first director/president, had dealt with children in crisis, private initiative and public service, and mental health.

This one, it was decided, would have as its theme "Looking Forward" and would deal with the older population in Texas in the 21st century. The charge to concerned citizens and experts in the field was to examine the situation in Texas and to try to send out satellites for the future.

The challenge presented was how to make this seminar a meaningful experience for the participants. How could an ambience be created which would help people think in innovative fashion? How would it be possible to address the oncoming implications rather than simply the current situation? In what ways could present planning help to prevent deterioration in future aging populations? How could one solve the needs of a changing population—the influx of "snowbirds" into the warm winter valley of Texas, for example?

Two central foci emerged. One was to draw on the expertise of knowledgeable persons from throughout the country by forming a planning advisory committee. The other was to consider ways in which a total atmosphere could be engendered for participants at the meeting by use of music, art, drama, and film.

Finally, many advisors were polled to help define possible outcomes of such a conference. Was increased knowledge about the aging population of the future a viable goal? Or, should definite aims include the encouragement of funding proposals for innovative projects in the area? Were there to be new insights into quality of life, policy issues, research possibilities regarding the future aging populations?

What was the possible? What were the intangible goals?

The task of making reality of the dreams then began. . . .

The efforts started with the selection of a blue ribbon advisory committee which drew from national leaders in the gerontological field, as well as from interested and involved citizens from throughout the state of Texas. The first session, held almost a year prior to the Seminar, was a daylong study of issues and suggestions for implementation. The second committee meeting, in the fall of 1983, dealt with the selected topics of workshops and means of bringing out specific themes and suggestions.

As the workshops were delineated and the Seminar's focus was honed, stimulus materials were sought in order to give the invited guests the opportunity to read and learn about the various topics before they arrived at the conference. It was hoped that this procedure would help to create a continuity of thinking and planning which would be vitalized before the meeting and would last long afterwards.

B. J. Skinner, behavioral psychologist, provided the first item of "homework." An article first published in *Psychology Today*, "Creativity in Old Age," rendered succinctly one man's opinion of meeting old age with determination and vigor. A special document on the demographics of the aging population in Texas was compiled by a University of Texas demographer. Papers by the two main presenters, Dr. Robert N. Butler and Dr. George L. Maddox, helped to set the theme.

Workshop leaders and others directly involved with the seminar were aided in their preparation by special training in group processes. Two sessions with Dr. Eva Schindler-Rainman gave those leaders the opportunity to be "at the ready" when the sessions began.

Invitees were proposed by members of the advisory committee. They represented a mix of age, economic, and ethnic groups. They lived in every section of the state, in rural or highly urban areas. They ranged in educational attainment from high school to post-doctoral levels. They were professionals; they were citizen volunteers.

What they shared in common was an interest in the situation of the aging in the state and a determination to effect positive results on behalf of those older members of the population.

The day's program is listed, and highlights of the Seminar follow.

Looking Forward: Texas and Its Elderly

SATURDAY, May 12, 1984

Opening Session—First Floor Auditorium, Thompson Center

* Welcome and Charge—Wayne H. Holtzman, Ph.D.
* Short Film: "Snowbirds" by Andrea Merrim
* "The Longevity Revolution"—Robert N. Butler, M.D.
* "Constructing the Future of Aging"—George L. Maddox, Ph.D.
* Reactions and questions from experts and audience

Concurrent Small Group Presentations and Discussions

I. Living Patterns and Changing Family Situations
II. Community Opportunities
III. Employment and Retirement Issues
IV. Housing
V. The Non-Anglo Elderly

Lunch

Small Group Discussions (continuing)

Closing Plenary Session

THE LONGEVITY REVOLUTION

Robert N. Butler

Mt. Sinai Medical Center
New York, New York

Texas is a wonderfully diverse state, ethnically, a beautiful state to think about as we look at the longevity revolution, by which I mean the spectacular increase in absolute number and relative proportions of older persons. The irony, of course, is that this remarkable increase occurs at a time of the possibility of thermonuclear extinction. Imagine the potential of human error and the fact the human kind has yet, unfortunately, not shown itself able to resolve conflicts and to live with differences of opinion and differences of systems across nations.

Gain in Life Expectancy

Despite media coverage and despite many discussions of the so-called crises in Social Security and Medicare, the social and public health challenge posed by the longevity revolution has not yet received the public attention and study required. The situation certainly is not discussed with the depth and sophistication that are necessary. Nor, in my judgment, has the longevity revolution really met the level of sophistication and imagination of government response and of a response from private sector institutions that will be required.

This is the century of old age. It is an unprecedented event. In less than a century we have gained over a quarter of a century of life expectancy. That is almost equal to the life expectancy gain over the preceding 5000 years, from the Bronze Age 3000 years B.C. This gain has been due to many things, but among them are

the massive reductions in maternal, childhood, and infant mortality rates and, even in the last decade, between a 25 to 40 percent reduction in deaths from heart disease and stroke.

All we need to do is think back on some of our great heroes and figures we have admired in the last centuries to realize what a specter death was stalking all along the life cycle. Thomas Jefferson lost five children before they reached maturity. His wife died giving birth to that last child. In 1830, just a little over 150 years ago, only one of three newborn babies lived out the full life. Today, eight of ten do. A dramatic difference.

In 1870, of 100 women who survived past 15—who did not die of diphtheria or chicken pox or scarlet fever—only 44 out of that remaining 100 lived out what we take for granted today as a natural life course for women. And in 1920, a ten-year-old had but a 40 percent chance of having two of the four grandparents alive. Now, there exists nearly an 80 percent opportunity of having two of the four grandparents alive.

Thus, we have seen a triumph of survivorship. While there has been no change in the inherent natural life span, which may be 110 to 120 years for human kind, life expectancy in this country and in most industrialized nations is now roughly 78 for women and 70 for men.

Feminization of Aging

And the longevity revolution is indeed worldwide, not limited just to the United States or industrialized nations. Numbers of persons over 60 will double between now and the year 2000. Japan, at the moment, is the fastest-growing aging society. But we have also seen a remarkable feminization of aging, that is to say, women are decisively outliving men, and all projections show that that will continue unless health habits—such as tobacco intake—do women in. Now, something like 150

women are present for every 100 men over 65; and when one reaches the 80s, the figures become even more striking—perhaps 200 women for every 100 men.

Old-Old Increase

Another point about this remarkable longevity revolution is that at the moment, throughout the industrialized nations, the fastest growing age group is 85+. And when the baby-boomers—that wondrous generation, 76 million strong, born between 1946 and 1964—reach "golden pond" in approximately 2020 or 2030, 20 percent of our population could be over 65. That would be one out of every five Americans. And since every projection in this past century with regard to older persons has turned out to be an underestimate, it is even conceivable that the percentage could be larger.

Isn't it surprising, then, that we are not celebrating, happy and joyous over the triumph of survivorship? We instead hear Gloomy Guses, we hear naysayers, we see inhospitable front-page cover stories in *Forbes* and *Newsweek* which are certainly not calculated to make older persons, the survivors, feel very much at home. *Forbes'* cover asks, "Can We Afford Our Old Folks?" *Newsweek* shows a young man, a male, holding up a human pyramid of nine people, getting grayer to the top. The portrayal is neither factually or numerically accurate nor is it a culturally sensitive cover. We are fast approaching the blame-the-victim or blame-the-survivor approach and not fully appreciating the underlying mechanisms behind the longevity revolution.

With the postponement of illness and death in time, little wonder that there would be a postponement or deferral of health costs to old age itself. Eighty percent of all deaths now occur after 60. We also blame the dependency ratio, which compares the numbers of older persons to "workers." Many older people

remain part of the working generation and are increasingly likely to do so. With zero population growth, if one adds up the number of individuals under 18 plus the number of persons over 65, over and against the so-called working generations, there has actually been a significantly decreasing dependency ratio.

We must certainly mobilize the productive capacity of older citizens. Already built into the "reforms" of the National Commission on Social Security Reform is the elevation of the Social Security age of eligibility to 67, phased in after 2011.

Resources Exist

In my judgment, no real shortage of resources exists, but there is remarkable shortage of imagination, prudence, and commitment in the way in which those resources are used. When we hear that older people should get out of way for the young or that the health costs of older people are a problem, it strikes me that we have to take some serious looks again at the underlying mechanisms. We physicians have hardly lost money since the passage of Medicare and Medicaid in 1965. What was passed in 1965 was an open-ended public trough, the kind of welfare situation from which we physicians unfortunately could benefit. As Senator John Heinz, Chairman of the Senate Special Committee on Aging, pointed out, 700 cardiac surgeons doing an average of less than three coronary by-pass operations per week averaged earnings of $350,000 a year during 1979.* I admire the skill of cardiac surgeons; I just suggest that it is time for medicine, the health care systems, and the hospitals to undertake major reforms. Not one more penny should come out of the benefits of older persons under Medicare.

* *An Information Paper*, "Medicare: Paying the Physician—History, Issues, and Options." Prepared for use by the Special Committee on Aging, United States Senate, March 1984. Washington, D.C.: U.S. Government Printing Office.

And we M.D.'s, I would hope, might, for a change, take some leadership in showing the way. Medicare is fundamentally flawed in terms of the way in which it is conceptualized and in the way in which cost containment fails.

The health care system is flawed, and to blame the victims or the survivors is quite inappropriate. There will be reform, if not a revolution, and it is probably going to be a very painful one as struggles emerge between the high-procedure, organ-oriented specialists, the surgeons, over and against the more comprehensive type of approach that is required in comprehensive diagnosis and case management as we have an increasingly aging society.

Committees are already at work. The Institute of Medicine, which is part of the National Academy of Sciences, contains a physician payment study group. In my visits to Washington I have been struck over the amount of increasing anger among both Republicans and Democrats about physicians. This negativism exists among staffs of both the Senate Finance Committee and the House Ways and Means Committee. Some extraordinarily painful decisions will need to be made by American organized medicine and the community of leadership in the movements of the older citizens . . . for example, AARP and the National Council of Senior Citizens and the Gray Panthers.

We clearly must conform health services to reflect more clearly the longevity revolution. We must be responsive to the continuum of care that is required, to the continuum that must include health promotion, disease prevention, home services, and not simply the pressures for acute hospital care or long-term nursing home care. The kind of paper which George Maddox wrote and which has been made available to you describing the English system is right on target in terms of the importance of providing the kind of effort that Sir Ferguson Anderson and others pioneered in Scotland some years ago.

Now it takes time, a great deal of time, for any society to respond to major changes, and I regard the longevity revolution as an historic, watershed change. We, after all, have not yet adjusted effectively to the industrial-technological-scientific revolution. And that goes back 200 years to the spinning jenny

and the steam engine. We still, after all, have industrial pollution, slums, the impact of the separation of the family from the workplace, structural unemployment. The longevity revolution was part of that industrial revolution.

Let me share three fantasies, and we will see which ones we might think ultimately will become reality.

Fantasy No. 1

The first fantasy: 1901, we are sitting in the Oval Office of Teddy Roosevelt, President of the United States. He has a visitor named Louis Pasteur from France who tells him about the germ theory and tells him that there is the concept of the Magic Bullet. We know it today as an antibiotic. He talks about Von Bering and his work on diphtheria antitoxin and various forms of immunizations. The demographers stroll in and they say, "Mr. President, we have 3½ to 4 percent of the population over 65, but about 1984 we are going to have nearly 12 percent of the population over 65." The head of the Office of Management and Budget comes in and says, "Really a very serious business. How are we going to be able to afford to have people over 50, because now the average life expectancy is 47." But if I read Teddy Roosevelt right, if such an imagined visit and discussion occurred in 1901, that affirmative, positive fellow would have said, "We are not going to shut down the National Hygienic Laboratory (which was the precursor of National Institutes of Health), we're not going to stop biomedical research, we are not going to stop improvements of water, sanitation. Full steam ahead. We'll simply adjust and move along."

Fantasy No. 2

Now let me share the second fantasy. It's 1984, 85, 86, 87, 88. We don't make major changes in social policies. We don't invest in research and development. We wait, if we do anything at all, until those baby boomers grow gray. And by then, 2020, four million people will be in nursing homes instead of today's 1.3

million. There'll be no cures or means of preventing senility. We won't have doctors who are properly trained in geriatrics. We won't have effective late life economic security. We will have depended instead upon the inadequate and inappropriate form of Individual Retirement Accounts, which are fine if you happen to be able to afford to buy them. However, if you take a look at projections in macro-economic demographic models, there will be a greater disparity between rich and poor in 2030. The only policy this country adopts is one based upon foregone taxes, namely the technique of the IRA.

Fantasy No. 3

Third fantasy; the good fantasy, the genuine transformation of our cultural attitudes and expectations and policies. Here efforts are really made to bring to an end the scourge of senility. The nursing home, once the iron lung of senility or geriatrics, evaporates—just as we have fewer tuberculosis sanitariums, just as we no longer hear the thump, thump of iron lungs as we did just 25 years ago. Second, through a massive new but staged and rational support of the National Institute on Aging, there will be marked reductions in the deleterious process of aging. This effort, utilizing a half a billion dollars a year by the year 1990, will be forged in order that effective behavioral, social, and biomedical research can be undertaken.

This third part of the fantasy reveals a productive old age, the generations sharing together the advantages that have come about as a consequence of automation and other technologies. All of us enjoy together the freedom from drudgery which we were taught in grammar school was the whole point of the industrial technological revolution. Instead of those machines' and computers' controlling us, we will at least in some way have found techniques for controlling them. And with the freedom from drudgery and premature aging we will also see opportunities for the kind of intellectual leisure that may evolve into some revolutionary developments in our understanding of our own behavior as human beings.

With the advance not only of neurobiology but of the social and behavioral sciences, we will experience the desperately needed revolution in our understanding of human behavior. The cave man approach, the cave man mentality, the cave man way of conflict resolution is hardly working. We will benefit, I suggest, from what is so often referred to as the aging of societies. I suggest we call it the maturation of societies.

The education, health care and development of youth are important objectives. In the developing world, approximately 40 percent of the population is under 15. With worldwide zero population growth, such terms as the greening of nations or the graying of nations would be conceptualized in quite different ways.

Incidentally, there are data that show in some countries like Bangledesh that when security for old age was made more possible, and more realistic, the birth rate declined. Clearly we need that type of life cycle view. There is much to do. We need to unlock human productivity in late life, develop affordable access to appropriate health care, achieve economic security in old age, and gain the equality of gender and ethnic life expectancies.

We can no longer tolerate the lower life expectancies of Hispanic and black Americans. We must deal with the gender gap. We have extraordinary differences in life expectancy between the sexes, with women's constituting 75 to 80 percent of nursing homes population. As a result of inadequate and disparate pay throughout life, women are less prepared economically for old age than men. We see the continuing perpetuation of Social Security inequities.

We must also, I hope, help men to live longer—help by both biomedical and behavioral scientific studies which would do a lot to alter the personal, cultural, social and economic problems experienced by both men and women in old age.

This year is a serious year, a Presidential election year, one in which it is clear that there will be a battle at some level over the matter of entitlements. For those who think that cutbacks in Medicare will only affect older people, I would remind them that 40 percent of hospital revenues derive from Medicare. That

being the case, there will be less nursing, less social work, fewer lab procedures, less of the things which are so important in providing decent care.

Let me indicate immediately, as I have earlier, the role that we doctors have played in beefing up those health costs and generating 70 percent of them, in fact. This statement is not meant to be insensitive to the need for cost containment, but only to say that reductions in benefit structures in Medicare or Medicaid are going to affect each and every one of us.

Finally we come down, as I think one always does, to the question of values—to the cultural, the ethical attitudes that a society sustains. I cannot accept the concept that ethics should be defined by economics. Economics, the pertubations of the society in terms of the recessional or inflationary expanse of activity on the economic front, is a variable that, so far as we know it, has gone on through the shape of time.

Ethics presumably reflects profound eternal verities that somehow transcend economic problems. I hope, with some wisdom, imagination, and thought and some understanding of the underlying mechanisms behind the added life span, that one day instead of our bemoaning it, we may more happily and joyously celebrate the longevity revolution.

CONSTRUCTING THE FUTURE OF AGING

George L. Maddox

Duke University
Durham, North Carolina

Visions of the future have consequences. Men and women in social groups construct dreams of their future, and these visions return the compliment. The dominant projections of the future in a society affect what men and women expect to happen, affect whether they think of themselves as pawns or active agents in determining their fates, and affect the societal projects they can imagine and design to construct alternative futures.

As a nation we have believed in the possibility and desirability of guided social change and, for the most part, have welcomed it. We have supported with public resources a very large number of change agents. Our pervasive general optimism about change appears, however, to be contradicted by a pervasive, persistent negativism about the future of aging.

In recent decades, gerontology and geriatrics have competed with economics for the title of the dismal science, documenting in detail decrements, impairments, and problems associated with aging. Older adults have been described primarily not only as having problems but also as being a problem for themselves, for their families, and for society. The ultimately pessimistic vision of the future of an aging society is illustrated by the question, "Why survive?" The difficulty in imagining a persuasive positive response has encouraged a failure of nerve and an immobilizing vision of our future as an aging society.

My thesis is that this negative vision is based on partial evidence and that a realistically optimistic view of an aging society is now justifiable. We can invent and construct the

future of aging in ways we are just beginning to imagine. My optimistic vision of the future of aging is soundly based on emerging evidence. This vision does not require that we ignore age-related problems which are intrinsic to the condition of finite human beings. Immortality is not part of our future. But the vision of the future of aging which can be realistically constructed includes a quality of later life for the average older individual and for society as a whole which is much better than we currently observe.

In constructing the future of aging, scientific research has played an important part and will continue to play an important part. We know that biology sets limits, but we are less certain now about those limits, and we are certain there is room to maneuver within them. In future geriatric and gerontological research, the behavioral and social sciences will play an increasingly important role in explicating what aspects of aging are modifiable and how. We need to know more about all aspects of aging than we do; but we already know far more than we have been clever enough or willing to apply.

Important as scientific research is in constructing a realistically optimistic vision of the future of aging, the critical components of a new and badly needed societal project to construct such a goal will be achieving political consensus about our national objectives for an older society and our ingenuity in translating these objectives into effective public policy and action.

Where We Are: Too Pessimistic a Vision of Later Life

Negative imagery about aging must be overcome. Studies of aging have continued to catalogue in exquisite detail the unwelcome concomitants of growing older. The risks of sickness, disability, depression, poverty, and isolation do increase

with age. Older people are often victims of both biology and social inequity; society is also a victim.

Some historians and comparative social scientists have described a world we have presumably now lost in which older people were appreciated and socially integrated in spite of their problems, although the more we know about the situation of aging persons in the past, the less idyllic that past appears to be. Economists report regularly the large proportion of the federal budget in the United States consumed currently by older adults; they forecast even larger figures for the future and speculate on the exact year by which Social Security and Medicare will be bankrupt. Health care specialists count long-term-care beds, project sobering estimates of future need, and think of fiscal constraints which will require older people and health care providers to be more frugal with public dollars.

When Dr. James Fries published his controversial article in the *New England Journal of Medicine* on natural death and the compression of morbidity,* he intended to make two hopeful and related propositions about the future of aging. He argued, first, that biological limits of the human life span will insure very limited additional age-specific life expectancy past age 85. Second, and more important, he argued that disabling biological, psychological, and social impairments might be delayed until a time nearer death, hence promising more years of active living.

Unfortunately, the demographic and epidemiologic evidence appears to be soundly against his first proposition; age-specific life expectancy at age 85 is demonstrably increasing. This increase is bad news indeed if the risk of disabling impairments cannot be decreased nor onset of impairment delayed. Interestingly, the evidence geared to refuting Fries' second proposition is not definitive at all, and that is potentially good news. Age-related risk for and the onset of disabling impairment apparently can be modified. We have every incentive to test this second proposition and to do so as quickly as possible. Yet one

* Fries, James F., M.D. "Aging, Natural Death, and the Compression of Morbidity." *New England Journal of Medicine*, Vol. 303 No. 3, 130–135. Waltham, Mass., July 17, 1980.

gets the impression from both the professional and lay publications that we are prepared to assume the worst.

The vision of older adults as inevitably victims of their biological destiny who in turn victimize and are victimized by society has continued to be pervasive and powerful. Worse, this vision of aging has constrained our imagination about possible alternatives for the future. Is a different future possible?

I think so.

A Distinctly New Vision

A distinctly new vision of the future of aging is emerging, reflecting a profound maxim of experimental and clinical science: If you want to understand something, try to change it. The maxim does not promise that we can change everything about life that displeases us. It does not promise we will be willing and clever enough to develop and implement a societal project to alter in beneficial ways everything we know about aging processes that are or might be modifiable. We do not know the limits of modifiability of aging processes. But we are now beginning to test the limits. Geriatricians and gerontologists are increasingly rediscovering and exploring the implications of this powerful idea.

This new vision of an alternative future of aging is surely one of the most significant developments.

What underlies this revolution in our vision about the future of aging?

Biomedical scientists who have been preoccupied in the past with documenting the age-related decrements that disable and ultimately kill us are now asking some new questions. For a long time they have noted and tried to distinguish genetically-determined *primary* processes of aging from the socio- and psychogenic *secondary* processes. They have increasingly documented considerable variability among older adults and between

groups and have clarified the interaction of primary and secondary processes. A few illustrations of the current revolution in the thinking of biomedical scientists about the modifiability of disabling illness will suffice.

The report of the Surgeon General, *Healthy People*, documents a revolutionary proposition: How we live affects the risk of illness, disability, and death. Behavior and lifestyles are among the most important risks predicting undesirable health outcomes.*

Take this one step further. Behavior and lifestyle, which are learned, can be modified. The difficulty lies not in the unmodifiability of behavior and lifestyles but in the limits of our willingness and cleverness to provide social and personal incentives leading to change.

Behavioral and social scientists have said some useful things about the modifiability of unhealthy behavior and lifestyles. First, societies are themselves experiments with human life on a grand scale, and these experiments can and do produce high risks for impairment and disability in the adult and later years. Values in our society clearly encourage and reinforce a great deal of unhealthy behavior among adults.

Further, societies have different resources to distribute to individuals, and they allocate those resources differentially among them. Different societal allotments demonstrably produce different health outcomes. Societies with few resources produce few individuals who survive to late life; societies that allocate resources differentially among their members experience differences in morbidity and mortality which match the distribution. The poorest, least educated, and most isolated individuals in all societies are sickest and most disabled, and they die soonest.

The initial revolution in public health occurred as societies achieved stable control of food supplies and both understood and applied principles of sanitation. The result was a population

* *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention.* Washington, D.C.: Public Health Department, Department of Health, Education and Welfare, 1979.

explosion and the radically changed average life expectancy at birth that eventually became the problem of population aging.

We are now awaiting a second revolution in which we implement what we already know about how to encourage healthy behavior and lifestyles and about how the differential allocation of social resources enhances desirable health outcome.

The issue of implementation is critical. The allocation of social resources within a society is largely explained by political choice. The relationship between lower social class status and both high morbidity and mortality is one of the best demonstrated findings of epidemiology which applies to older adults as well as to adults generally. It is risky to grow up and grow old lower class. We need to broaden our view of risks beyond dietary habits, drug use, exercise and stress to include specifically the class-related risks of ignorance, poverty, and social isolation. And we need to recognize an appropriate degree of public responsibility for tolerating these modifiable risks.

Our current social values and public policies encourage and accept risky lifestyles and a high level of poverty, ignorance, and isolation both in adulthood and in later life. These values and policies ensure that health care really means medical care and medical care in hospitals and institutions. We prefer to think of aging as a biomedical problem with social implications rather than aging as a social problem with biomedical implications. We may not be able to imagine and implement anything different that would be more satisfactory. But we should believe and bet that we can and act as though we can. In any case, we must not pretend that primary processes of human aging inevitably produce the outcomes we observe. As Pogo stated profoundly, we have met the enemy and he is us.

A new societal project for our aging society is imperative.

A New Societal Project

The time has come to explore a new vision about the modifiability of human aging and the experience of aging and to commit ourselves to a societal project designed to explore the practical implications and applications of that new vision. We do not know the limits of the possible. The progressive aging of populations worldwide, however, provides a powerful incentive to think carefully and urgently about alternative futures. Or, if you need a personal incentive, remember that the future under consideration is our own, not just the future of the currently old.

My abbreviated five-point agenda for mobilizing a societal project to design the future of aging it intends and determines to construct is simple:

Focus on the Life Course

First, we need to affirm and to believe that the human life course is a single fabric. We must not neglect those who are currently old. It is never too late for older adults to benefit from social policies that insure an adequate income, adequate and equitable health care, supportive social networks, opportunities for learning, and healthful behavior and lifestyles. If we concentrate only on the currently old, however, we condemn ourselves and our children to inherit the current problems of our aging society—only worse.

Quality of life in the later years is the product of a lifetime. To me the most fearful aspect of the future of aging is our society's willingness to accept as inevitable for both children and adults high rates of functional illiteracy, of unhealthy behavior and lifestyles, of poverty, of social disorganization, of unemployment, and a health care system which focuses on illness rather than health. Risky and unhealthy behavior and lifestyles can be modified. Healthy human environments can be constructed. Investments now in changing how both children and adults live is an investment in a better future for an aging population.

Reshape Health Care

Second, our national project must include rethinking and reshaping our system of health care. We tend to view the community as an alternative to institutional care. We should take the opposite position: institutionalization is an alternative of last resort to community care. We pay a very high price for a medicalized, institutionally-biased system of care which produces unnecessarily unsatisfactory outcomes in terms of both cost and care and less than achievable levels of independence in the later years. Those who have the responsibility for geriatric care are acutely aware of the limitations of our current ways of providing aid. We institutionalize too many older people in the wrong places and often for the wrong reasons. And whatever good institutionalization does for the health status of older adults, the care provided too often has the unwanted effect of increasing functional dependence.

We have not achieved and are not going to achieve the health we need by federal and state regulations and fiscal strategies such as Diagnosis Related Groups intended to achieve cost containment. Health care for our society in general and for older adults in particular must be organized fundamentally to ensure basic pre-paid comprehensive care that includes care in the community as its basic component. Our currently uncoordinated, fee-for-service non-system of care will not achieve what we need because it cannot provide an integration of health promotion, disease prevention, and care of the chronically as well as acutely ill.

Care in the community is not an incidental supplement to institutional care. Actually it is the other way around. Most care of older persons currently is in the community and is paid for by private, not public, sources. Institutional care at its best is a supplement for community care.

An Intergenerational Contract

Third, our new societal project must include a rediscovery of the social contract which binds a society together—its old, its middle-aged, and its young—in its understanding of how resources are to be allocated to ensure the welfare and the health of all its people. It is in our national interest to improve literacy and secure the economic and social well-being of all our citizens, including older ones. Social Security and Medicare are not concessions which should be grudgingly conceded to old people. Basic personal security is a fundamental issue in public policy of primary importance for all of us. Adults who are virtually certain to have responsibility for their older parents are foolish if they do not understand the importance of viable programs to ensure well-being in the later years.

Integrated Public Welfare Policy

Fourth, our societal project must focus on public policy that integrates health, income security, education, transportation, and housing. We are paying a high price for our fragmented approach to policy. Housing is one of the key but neglected policy issues of our time. We must turn our current policy, which encourages institutionalized care, on its head.

We desperately need, for an aging society, a housing policy which facilitates the movement of older adults from housing which they cannot manage and do not need to more appropriate habitation, which should be supplemented by organized community care services as required. From this perspective, hospitals and long-term care facilities would become only one type of shelter on the continuum, a type with maximum support services provided. Until appropriate housing alternatives are provided, we will necessarily continue to institutionalize older adults inappropriately.

Fifth, if we intend to understand the processes and experience of aging, we need to explore the limits of modifiability, beginning with simple but important experiments. Lifestyles are changing: diets are better; we smoke less and are more conscious of the dangers of drug use; we exercise more; we understand how stress can be managed effectively; we can increase perceived personal control of our lives; we know how to create healthy human environments; we understand the importance of matching personal characteristics and environments which increase self-actualization. With increased vigor, we must translate what we know into action.

Many modes exist to improve the quality of life. The crucial question is whether we have the intention and will to act.

Toward the Future

I do not assume that commitment to a societal project to construct the future of aging will result in simple solutions. But I do believe that in commitment to this project we will discover that our problems have less to do with our available knowledge and resources than with our values, intentions, and will to act. What is the future of aging we will to construct, whose limits we wish to test? There is no better place than Texas to begin a discussion of the future of aging we wish to construct. There is no better time than now. You know my agenda. What is yours?

RECOMMENDATIONS

Following are recommendations which represent a minute portion of the planning, discussing, compromising, and thinking that went on intensively during the day. The training for group leaders, the materials sent in advance, and the plenary sessions all served as impetus for the specific discussions on the five topics. Special consultants served as experts in each group, and some were divided into subgroups for closer scrutiny of particular aspects of the subject.

The distillation of four and one-half hours of group consultation and, sometimes, confrontation, is reflected here. The recommendations might well serve as guideposts for groups interested in and concerned with making life for older people increasingly meaningful in future years.

***Group I**—Living Patterns and Changing Family Situations*

1. Establish mechanisms/programs/incentives for out-of-state families to receive information about and to provide assistance to elders in the family who live in Texas.
2. Provide social support and financial incentives for establishing alternative living situations for the elderly (i.e. cooperative housing ventures, shared living situations—older living with younger families, etc).
3. Develop community education programs to assist people in knowing their options about and planning for such issues as retirement, the aging process, and their financial, health and housing needs *before* actual decisions have to be made.
4. Encourage and fund both research and programatic activities designed to:
   (a) help the elderly maintain as much independence, autonomy and "social connectedness" as possible (for example,

experimenting with mobile grocery stores, various kinds of communication equipment, new technology, etc.);

(b) increase elderly people's awareness of an involvement in community life and political activities—i.e., helping them to pursue leadership roles regarding issues and policies that affect their age group;

(c) focus special attention on the poor elderly—particularly with respect to documenting their needs and evaluating the existence and adequacy of services they are presently receiving.

5. Establish local, state, and national information and referral networks regarding the availability of resources and services (ranging from financial assistance and housing opportunities to counseling and social services) for the elderly and their families.

6. Develop programs that foster neighborhood responsibility (involving schools, churches, etc.) for the elderly in the community—this could involve a more creative use of resources like using school and church buses as transportation options for the elderly or setting up bartering of services, with the elderly participating in child care in exchange for repairs on their homes, etc.

7. Solicit corporate philanthropic contributions which are tax deductible to help sponsor particular programs for the elderly within the corporation's community.

8. Ask local chambers of commerce to support actively and monitor the 5% Industrial Council Funds that have been allocated to the elderly.

9. Employ a wider range of health and human services professionals to do routine monitoring of the elderly—particularly with respect to preventing any unneccessary deterioration in health or social services.

10. Establish and expand insurance coverage for appropriate alternatives to hospitalization for the elderly—such as outpatient coverage, family care-takers, visiting nurse service, etc., especially with respect to chronic and costly illnesses.

***Group II**—Community Opportunities*

1. Rewrite Medicare legislation (Title XVIII) to support community care (versus just acute care).
2. Facilitate appropriate private family assistance and home health care through third party public and private resources.
3. Organize a local group to influence the local media to portray realistic and appropriate role models as well as to impart accurate information on aging and other related futuristic issues (scientific, high tech).
4. Change attitudes toward older persons by modifying curricula of public and private schools, including professionals (teachers, ministers, physicians, etc.) and emphasize pre- and post-retirement training by industries and governmental organizations.
5. Re-evaluate medical planning, services, and insurance.
6. Expand housing alternatives to permit penalty-free living arrangements.
7. Present positive images of maturing society through communication, education, and volunteerism.
8. Recognize and encourage mature leadership to incorporate the mature population into the mainstream of life.
9. Initiate education about life-span development to enhance personal satisfaction and increase participation in the democratic process.
10. Encourage integration of planning development and implementation of services by providers and non-providers to make services more accessible, available, cost-efficient, and closely tied to real needs.
11. Utilize media to develop public awareness of ageism and ways to eradicate ageism.
12. Prepare educators, developers, and planners to create and maintain age-integrated communities.

***Group III**—Employment and Retirement Issues*

1. Develop a national pension plan for all employees that would include survivor benefits, portability of pension benefits from one employer to the next, and elimination of Social Security benefits.
2. Appoint a statewide task force to focus on lifelong continuing education in such areas as pre-retirement training, transitional training, and training for second and third careers.
3. Eliminate age-related mandatory retirement policies (using instead performance and health indicators) and support for retraining of employees to ensure lifelong job skill development.
4. Make war on stereotypes. Use the media and other resources to ensure that people understand that there are such things as successful older workers and that retirement can be fun. Disseminate information on model programs and exemplary practices.
5. Utilize financial mechanisms such as home equity conversion and property tax deferrals on homesteads of older owners to increase the older person's overall ability to remain independent and purchase needed support services.
6. Develop a national health plan that addresses the need to foster wellness rather than only treat sickness, a plan that moves away from fee-for-service reimbursement to a more cost-effective model.
7. Encourage elders to do volunteer work.
8. Use elders as a political force. Encourage them to become more active advocates on social issues.
9. Work with institutions, corporations, and small businesses to develop models of training/retraining and different work patterns such as variable shifts and hours, sabbaticals, and home employment.

10. Encourage research on the effects of restructuring the workplace. Disseminate findings on worker productivity and benefits to businesses.
11. Include long-term care and supportive services within the scope of mandatory health care benefits for all employees and survivors.
12. Continue the development of alternatives to institutionalization for older persons and the removal of barriers to families who care for their aged.
13. Promote the focus of medical research on health problems of older women and on efforts to achieve a better balance between the longevity of males and females.

Group IV—Housing

1. Develop a statewide task force focused specifically on shared housing. Its responsibilities would include education of the public, study of legal considerations, exploration of funding resources, exploration and recommendation of government incentives.
2. Encourage research which explores different models of shared housing, adaptation of existing models to Texas, and marketing techniques.
3. Mobilize community resources such as volunteers, churches, local and state agencies, and the elderly themselves to provide systematic and holistic housing and services for the entire range of special populations of elderly in their community.
4. Establish new partnerships between the public and private sectors to attempt to offset the lack of support services for elderly residents in subsidized housing programs.

5. Develop and implement specialized programs which address the differential needs of the young elderly and the old elderly. Housing which enables the older elderly to maintain some semblance of independence is a priority.
6. Develop home support community-based services incorporating both formal community programs and informal social networks.
7. Promote age-integrated communities that provide a wide range of housing options and offer diverse numbers and types of health and social services.
8. Design legislation that is aimed at facilitating housing for the elderly, specifically focusing on financing for the development of housing, housing codes which would allow different housing options to develop, and regulations aimed at ensuring that quality care and financial protection are provided for the elderly.
9. Rethink and restructure the reimbursement and financing of long-term care.
10. Set up reimbursement systems for long-term care which acknowledge the need for social, psychological, recreational, and familial aspects of care as well as medical care. Health care teams need greater multidisciplinary training and more serious training in geriatrics.

Group V—*Non-Anglo Elderly*

1. Recognize and promote the idea that we live in a multicultural and not a majority-minority society.
2. Build into delivery systems differentiation between cultural and economic issues in order that inherent cultural strengths can be used as elements in program planning.

3. Sensitize delivery systems along both sides of the Texas-Mexico border to promote agency interaction.
4. Promote governmental programs' addressing the vagueness of many rules and regulations such as eligibility requirements or service areas and communicate this information in a clear and multi-cultural manner.
5. Mandate information dissemination by services and agencies in a multi-cultural and multi-media format. Informal dissemination sources such as laundromats, doctors' offices, neighborhood councils, clinics, and churches should not be overlooked.
6. Unite efforts of service agencies, churches, and many other organizations in supporting the family as a power base for the elderly.
7. Expand research concerning abuse and neglect of the non-Anglo elderly in Texas. With additional information about this issue, efforts should be made to lobby for protective legislation.
8. Insist that all information dissemination be in culture-sensitive language and format.
9. Award tax credit to employers who hire the non-Anglo elderly.
10. Lower the Social Security eligibility age requirements to reflect the lower life expectancy of the non-Anglo elderly.
11. Lobby for income tax breaks for non-home owners.
12. Develop legislation that will require employers to provide culturally-sensitive pre-retirement education programs.
13. Develop more affordable living options such as shared housing, supervised housing, or independent living arrangements.
14. Encourage planners to develop inter-generational living arrangements.

15. Promote the appointment of more elderly non-Anglos on city/county planning committees and their inclusion in the entire planning process in order to increase their participation in developing housing options.

16. Develop appropriate research concerning the scope of non-Anglo elderly housing concerns.

17. Recognize underlying factors in differential mortality and develop agendas to address diabetes, hypertension, and prenatal and maternal health care as sources for early mortality.

18. Conduct research on how social class factors within ethnic populations affect health status.

19. Make health care services more appropriate and accessible through increased staff sensitivity to cultural differences, linkages with indigenous health care providers, more outreach services, and flexible service hours.

20. Develop culturally relevant programs to address risk factors, screening and diagnosis, follow-up, and continued monitoring.

21. Direct more funds toward services and place more non-Anglos on health care staffs.

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EPILOGUE

Finally. . .

Looking both backward and forward, what has resulted from the Fourth Robert Lee Sutherland Seminar?

Were people enriched? Enlighted? Energized?

Inspired or fatigued?

Moved to action or quiet acceptance of information?

What really happened, and how can results be measured?

As in all areas of mental health education, many intangible factors impinge on possible evaluation of such a conference.

Perhaps results can be measured partially in emotional response and commitment of participants. Or, they may be evaluated by information gleaned. They may lie in personal insights about one's own aging process.

Commendations received following the Seminar tell an upbeat story. A networking effort among aging programs begun by one community strengthens the positive image.

Still, questions surface.

Should definite follow-up structure be instituted after such seminars in order to ensure careful reporting of results?

Should the meetings be open to a general public or kept to an informed working group?

Answers may well lie, not in tabulations of numbers, but in the increased sensitivity of a group of caring human beings. The challenge remains . . .